

EXHIBIT J

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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COYNESS L. ENNIX, JR., M.D., as)
an individual and in his)
representative capacity under)
Business & Professions Code)
Section 17200 et seq.,)

CERTIFIED COPY

Plaintiff,)

vs.) No. C 07-2486

RUSSELL D. STANTEN, M.D., LEIGH)
I.G. IVERSON, M.D., STEVEN A.)
STANTEN, M.D., WILLIAM M.)
ISENBERG, M.D., Ph.D., ALTA BATES)
SUMMIT MEDICAL CENTER and Does 1)
through 100,)

Defendants.)

CONFIDENTIAL

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DEPOSITION OF
JOANNE JELLIN, PsyD

December 20, 2007

REPORTER: BRANDON D. COMBS, RPR, CSR 12978

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1 coordinator level of peer review, then I won't ask more
2 questions and we'll just get another witness to testify
3 to those things.

4 MR. VANDALL: Object that the witness has said
5 she does not know what questions you're asking. If you
6 have questions you'd like to ask, she will respond if
7 she's able to.

8 MR. SWEET: Q. Okay. What percentage of peer
9 review matters start at the quality improvement
10 coordinator level?

11 MR. VANDALL: Asked and answered.

12 MR. SWEET: Q. You can answer.

13 A. I believe I've answered that question.

14 Q. Which is what, that you don't know?

15 A. No. I believe I answered the question, that
16 there are several ways that peer review issues are
17 identified. That is one of them.

18 Q. With all due respect that's not an answer to
19 my question. I want to know what percentage of all the
20 different ways -- what percentage start at the quality
21 improvement coordinator level?

22 A. I can't quantify that.

23 Q. Can you explain for me how a case progresses
24 from the quality improvement coordinator level to the
25 physician review level?

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1 A. My understanding of the process is when it
2 fails a screen, it is referred to a physician reviewer.

3 Q. And then what happens at the physician
4 reviewer level?

5 A. If the physician reviewer reviews the medical
6 record and based on his clinical knowledge decides that
7 the case needs no further review, it's my understanding
8 it's closed.

9 If he or she feels that there is a question or
10 that, in fact, it does not meet the indicator, it's
11 referred to the full committee review.

12 Q. And that would be either the department review
13 or a division review if there's a division?

14 A. That's correct.

15 Q. In this case that you're testifying about,
16 there was a division, cardiothoracic division. Do you
17 ever sit in on the cardiothoracic peer review committee
18 meetings?

19 A. I'm actually not testifying about this case.
20 I'm testifying about the peer review process.

21 Q. Do you ever sit in on the cardiothoracic peer
22 review committee meetings?

23 A. No.

24 Q. Are those meetings tape-recorded?

25 A. I do not know.

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1 Q. And, again, are there circumstances where the
2 cardiothoracic surgery peer review committee level of
3 peer review could be skipped and the issue could start
4 somewhere else?

5 A. I believe I've answered that question, but
6 yes.

7 Q. And again, the answer is similar to the
8 skipping of other levels, that the circumstances warrant
9 it or in the discretion of the officers?

10 A. Correct.

11 Q. Okay. Surgery peer review committee meetings,
12 do you sit on those meetings?

13 A. No, I don't.

14 Q. Do you know what percentage of the matters
15 that reach the surgery peer review committee go up to
16 the medical executive committee?

17 A. No, I don't.

18 Q. Do you know what issues that reach the surgery
19 peer review committee go up to the medical executive
20 committee level?

21 MR. VANDALL: I'm sorry. I don't understand
22 the question.

23 MR. SWEET: Q. Was that unclear?

24 A. Yeah.

25 Q. Of the peer review issues that come to the

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1 body known as the surgery peer review committee, I'd
2 like to know which issues then reach the medical
3 executive committee, what types of issues? If you know.

4 MR. VANDALL: Again, we're not responding to
5 substantive questions about peer review at this
6 deposition, but procedurally we can respond.

7 THE WITNESS: I can respond to that
8 procedurally.

9 MR. SWEET: Q. Okay.

10 A. Procedurally, any circumstance that is
11 requested by the department of surgery to go to the
12 medical executive committee will go.

13 MR. SWEET: And, Matt, you're going to advise
14 your witness to not answer the questions of the exact
15 issues that she's aware of that have progressed from the
16 surgery peer review committee to the MEC?

17 MR. VANDALL: We are not responding to the
18 substantive peer review questions at this deposition.
19 We've provided a chart regarding MEC level peer review
20 to plaintiff in response to special interrogatories, and
21 I think the parties' positions with respect to the peer
22 review are currently in dispute, and it's not a proper
23 line of questioning at this deposition.

24 MR. SWEET: I'm not asking you what your
25 position is, are you advising your witness not to

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1 A. To me it says that in the medical staff
2 leadership's discretion they can take appropriate action
3 given the circumstances in front of them.

4 Q. Regarding ad hoc committee review or
5 investigation, would it be appropriate to have, as a
6 member of an ad hoc committee investigating peer review
7 issues at the behest of the medical executive committee,
8 a member of the board of directors on that ad hoc
9 committee?

10 A. What was the beginning of your question? Was
11 it appropriate? Is that what you said?

12 Q. Yeah.

13 MR. VANDALL: Under what circumstances?

14 MR. SWEET: Q. Any circumstances.

15 A. Not in my experience. It hasn't happened in
16 my experience.

17 Q. Who decides the membership of an ad hoc
18 committee that's convened to investigate peer review
19 issues?

20 A. Can you clarify what you mean by peer review.

21 Q. Well, when the MEC requests an ad hoc
22 committee to do an investigation, who decides the
23 membership of the ad hoc committee?

24 A. The leadership. Believe that's spelled out in
25 the bylaws.

STATE OF CALIFORNIA

I do hereby certify that the witness in the foregoing deposition was by me duly sworn to testify the truth, the whole truth, and nothing but the truth in the within-entitled cause; that said deposition was taken at the time and place therein stated; that the testimony of the said witness was reported by me, a Certified Shorthand Reporter and a disinterested person, and was under my supervision thereafter transcribed into typewriting; that thereafter, the witness was given an opportunity to read and correct the deposition transcript, and to subscribe the same; that if unsigned by the witness, the signature has been waived in accordance with stipulation between counsel for the respective parties.

And I further certify that I am not of counsel or attorney for either or any of the parties to said deposition, nor in any way interested in the outcome of the cause named in said caption.

IN WITNESS WHEREOF, I have hereunto set my hand the 28th
day of December, 2007.



Certified Shorthand Reporter

CSR No. 12 978

EXHIBIT K

Certified Copy

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COYNESS L. ENNIX, JR., M.D., as an)
individual and in his representative)
capacity under Business &)
Professions Code Section 17200 et seq.,)
)
Plaintiff,)
vs.) Case No. C 07-2486
) WHA
RUSSELL D. STANTEN, M.D., LEIGH I.G.)
IVERSON, M.D., STEVEN A. STANTEN, M.D.,)
WILLIAM M. ISENBERG, M.D., Ph.D.,)
ALTA BATES SUMMIT MEDICAL CENTER and)
does 1 through 100,)
)
Defendants.)
_____)

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DEPOSITION OF LEIGH I.G. IVERSON, M.D.

The following deposition was given on the 19th
day of December, 2007, commencing at the hour of 9:28 a.m.,
before Jenna Osborn, a Certified Shorthand Reporter, License
Number 8681.

The witness personally appeared at 409
Washington Street, Monterey, California.

1 BY MR. EMBLIDGE:

2 Q. Russell Stanton, is he not someone you've
3 golfed with?

4 A. I think I took him out to play golf two, maybe
5 three times over the years we were together.

6 Q. What about Dr. Arthur Stanton?

7 A. I don't believe I ever played with him. No, I
8 did play with him once. I think I played with him once
9 also.

10 Q. What about Dr. Steven Stanton?

11 A. I think I played with him twice.

12 Q. Would you call Dr. Steven Stanton a friend?

13 A. No.

14 Q. How did Dr. Kahn come to join your practice?

15 A. When Russell and I were looking for a third
16 person, he was recommended to us by I believe Art Thomas who
17 was one of his professors at UC. And we interviewed him and
18 talked to him and offered him a job.

19 Q. And he -- he was your partner from when to
20 when approximately?

21 A. I believe he joined us in '98 or '99.

22 Q. And you left in 2000 --

23 A. Six.

24 Q. Six.

25 Is he someone you socialized with outside of work?

10:25

10:25

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10:27

1 A. No. 10:27

2 Q. Did you golf with him? 10:27

3 A. No. 10:27

4 Q. Did there ever come a time where you had any 10:27

5 concerns about his medical practice?

6 A. No. 10:27

7 MS. McCRAIN: Same objection with respect to 10:27

8 Dr. Kahn's privacy. 10:27

9 THE WITNESS: No. 10:27

10 BY MR. EMBLIDGE: 10:27

11 Q. Did you -- do you have any reason to believe 10:27

12 that Dr. Russell Stanton -- I'm going to start this question

13 over. Trying to figure out a way to do this without a

14 double negative but I don't know if I can.

15 In your experience with Dr. Russell Stanton, do you 10:28

16 have any concerns that he would not honestly express his

17 views about Dr. Ennix's patient care?

18 MS. McCRAIN: Objection, vague, compound, improper 10:28

19 opinion.

20 BY MR. EMBLIDGE: 10:28

21 Q. Do you want that again? 10:28

22 A. Do I have any concerns that he would not? 10:28

23 Q. That he would not -- 10:28

24 A. Express his opinion. 10:28

25 No, I don't. 10:28

1 Q. Do you have any concerns that Dr. Kahn would
2 not honestly express his opinions about Dr. Ennix's patient
3 care?
4

10:29

5 MS. McCALAIN: Same objections. It's over broad,
6 compound, lacks foundation.
7

10:29

8 THE WITNESS: No, I do not.
9

10:29

10 BY MR. EMBLIDGE:
11

10:29

12 Q. Do you know Dr. Hon Lee?
13

10:29

14 A. Yes.
15

10:29

16 Q. Have you ever worked with him?
17

10:29

18 A. No. Well let -- let me ask you what -- what
19 do you mean have I ever worked with him?
20

10:29

21 Q. Cared for the same patient.
22

10:29

23 A. No.
24

10:29

25 Q. Did you ever develop any concerns about
Dr. Lee's medical practice?
26

10:29

27 MS. McCALAIN: Objection, invasion of Dr. Lee's
28 privacy, and lack of foundation that this witness is in a
29 position to judge that.
30

10:29

31 THE WITNESS: I -- I have no information of which
32 to base an opinion like that.
33

10:29

34 BY MR. EMBLIDGE:
35

10:29

36 Q. Well, you sat on the Cardiothoracic Peer
37 Review, correct?
38

10:30

39 A. Based on that experience, I do not.
40

10:30

1 discussions?

2 A. I don't remember. That's long ago.

10:54

3 Q. Sure.

10:54

4 Now the cases that the physician does not clear --

10:54

5 A. Yes.

10:54

6 Q. -- is there any discussion of that case at the

10:54

7 Cardiothoracic Peer Review Committee during which time

10:54

8 doctor A is present?

10:54

9 A. No.

10:54

10 Q. And that's been your experience both at

10:54

11 Doctors and Summit?

10:54

12 A. Yes.

10:54

13 Q. Was that your experience when Russell Stanton

10:54

14 was the chair of the Cardiothoracic Peer Review Committee?

10:55

15 A. Yes.

10:55

16 Q. At Doctors, were you aware at anytime that a

10:55

17 physician had his or her cases examined by outside peer

10:55

18 review?

10:55

19 A. I do not recall that.

10:55

20 Q. At Summit, other than Dr. Ennix, are you aware

10:55

21 of any physician who has been examined through outside peer

10:55

22 review?

10:55

23 A. Yes.

10:55

24 Q. Approximately how many?

10:55

25 MS. McCALAIN: Dr. Iverson, I caution you not to

10:55

1 A. No. It didn't happen very often. If it did, 11:11
 2 if it was a non-cardiac case, I would have probably asked
 3 Stallone to do it. If it was a cardiac case, I would have
 4 asked Russell and Junaid or Coy to do it. But I was able to
 5 keep up. It was unusual for me to turn out one of those
 6 cases. I would have done it more except it was an onerous
 7 job and it was hard to get it done on time. And it just
 8 became less painful if I would just suck it up and get it
 9 done myself.

10 Q. During the period of time when Dr. Ennix 11:12
 11 returned to practice with you at Summit in 2001 forward, is
 12 there -- did there come a time when you reviewed one of his
 13 cases and determined that there were care issues?

14 MS. McCLEAIN: Objection, lack of foundation. 11:13

15 THE WITNESS: I have no recollection of reviewing 11:13
 16 any of his cases.

17 BY MR. EMBLIDGE: 11:13

18 Q. Did there come a time where you participated 11:13
 19 in the discussion at the Cardiothoracic Peer Review
 20 Committee about one of his cases and you believed there were
 21 care issues? 11:13

22 MS. McCLEAIN: Objection, lack of foundation. 11:13

23 THE WITNESS: I believe there was some issues about 11:13
 24 documentation. 11:13

25 /// 11:13

1 the Surgery Peer Review Committee, does he ever appear at
2 the committee?

3 A. No. 11:19

4 Q. Were you involved in meetings over your 11:19
5 career, were you involved in meetings at the Surgery Peer
6 Review Committee where cardiothoracic surgeons' cases were
7 reviewed by the Surgery Peer Review Committee?

8 A. I believe so, yes. 11:19

9 Q. Other than Dr. Ennix? 11:19

10 A. I believe so. 11:19

11 Q. In any of those cases are you aware of an 11:19
12 instance where the Surgery Peer Review Committee found there
13 to be a care issue but the cardiothoracic peer reviewer had
14 not found there to be a care issue?

15 A. No. 11:20

16 I have to qualify that. Because what I don't 11:20
17 remember is if I ever was involved where a referral was made
18 outside the division of cardiothoracic surgery.

19 Q. Okay. 11:20

20 A. I don't think one was but I can't swear to 11:20
21 that.

22 Q. Okay. But what I'm trying to get at is a case 11:20
23 where a cardiothoracic peer reviewer has reviewed a case,
24 found there to be no care issues, but that case nonetheless
25 was reviewed by the Surgery Peer Review Committee, and the

1 Surgery Peer Review Committee found care issues or felt
2 further review was necessary?

3 MS. MCCLAIN: Objection, compound. That's a 11:21
4 different question. Lack of foundation.

5 THE WITNESS: I don't recall that happening. 11:21

6 BY MR. EMBLIDGE:

7 Q. Have you ever been on the Medical Executive 11:21
8 Committee?

9 A. Yes. 11:21

10 Q. In what capacity? 11:21

11 A. Both as to Chief of Surgery, which is one of 11:21
12 the members of the Executive Committee, and also I was
13 elected as the member at large from the department of
14 surgery. Surgery has two members on the Executive
15 Committee, as department of medicine a member at large and
16 the department chief. And I was elected as the member at
17 large two or three times. So I've been on the Medical
18 Executive Committee I know three times, and I think I was
19 also a fourth time quite a few years ago.

20 Q. In your experience how often does that 11:22
21 committee meet?

22 A. Monthly. 11:22

23 Q. With the same qualification? 11:22

24 A. Yes. But fewer misses. 11:22

25 Q. Other than Dr. Ennix, are you aware of any 11:22

1 Q. Okay?

11:43

2 A. I understand.

11:43

3 Q. So in order to say talking about the minimally
4 invasive cases and have them refer to these procedures as
5 opposed to more general routine types of minimally invasive
6 cases that had earlier been performed, how would you
7 describe those cases?

11:43

8 A. Cases done with groin cannulation, plus
9 retrograde cardioplegia line placed by transesophageal echo,
10 through -- and that's the first part. And then the surgery
11 itself is done through a limited incision.

11:43

12 Q. Okay. And that is your understanding of the
13 types of cases that Dr. Isenberg is asking you about?

11:44

14 A. Yes.

11:44

15 Q. Before Dr. Ennix performed those cases at
16 Summit had you attempted to perform such a case at Summit?

11:44

17 A. We -- by we, I mean we did a case of mine that
18 Dr. Kahn did. I was not the surgeon. Patient was aware of
19 that. Because the patient wanted a minimally invasive case
20 and in discussing it with them, I told them that Dr. Kahn
21 was going to be the surgeon and that I would be the
22 assistant. So that's the first thing. So while it's
23 classified as my case, technically I wasn't the surgeon,
24 somebody else was.

11:44

25 Q. Great. Didn't realize that.

11:45

1 A. Okay. And the patient was aware of that. 11:45
2 Fully informed and consented and written in the chart, all
3 that stuff. So if you're talking about that case, which I
4 assume you are, we did the case through the median
5 sternotomy. An incision up here (indicating).

6 Q. What was the word you said before sternotomy? 11:45

7 A. Median. Middle. 11:45

8 Q. Right. Sure. 11:45

9 A. And we did it because we wanted to use all of 11:45
10 the equipment that you use through the lateral incision, the
11 small lateral incision to do it when things were open so
12 that we could see what we were doing and understand better
13 how the equipment worked. I am uncertain as to whether -- I
14 don't remember whether we put the retrograde cardioplegia
15 line in by transesophageal echo through the neck, and
16 therefore it may not fulfill the criteria that you just
17 wrote down there, that we just gave to define the minimally
18 invasive surgery.

19 So I'm not sure if by those criteria this was a 11:46
20 minimally invasive surgery.

21 Q. Okay. 11:46

22 A. Okay? Is that -- do you understand what I 11:46
23 mean?

24 Q. I hope so. 11:46

25 A. Okay. And so we did the case and we had 11:46

1 problems using the aortic cross clamp that you need to use
2 in the minimally invasive case that you are referring to
3 that Coy did that I'm assuming that is done through this
4 small incision over here (indicating).

5 Q. Pointing to, for the record? 11:47

6 A. Excuse me. You can't write that down. The 11:47
7 anterior thoracotomy. Because the cross clamp did not work
8 the way we should, we just converted to an open case and did
9 it the routine way.

10 Does that answer what you were after? 11:47

11 Q. I hope so. I mean, I've seen references to 11:47
12 this. Now I understand more about it.

13 A. Okay. 11:47

14 Q. Did that involve groin cannulation? 11:47

15 A. Yes. 11:47

16 Q. Okay. 11:47

17 A. Well wait a minute. I don't have that case in 11:47
18 front of me. I can't swear to anything without the record
19 to know.

20 Q. To the best of your recollection. 11:47

21 A. I think we did the groin cannulation. I also 11:47
22 think we did not do the transesophageal echo placement of
23 the retrograde catheter but we might have. I'm not certain.

24 Q. Other than you and Dr. Kahn, who was involved 11:48
25 in that surgery?

1 A. I don't remember. 11:48

2 Q. You had never done a case like that before, 11:48
3 correct? 11:48

4 A. Well that's not quite true. 11:48

5 Q. Okay. 11:48

6 A. I -- I don't remember when, late '80s, early 11:48
7 '90s, I did a series of minimally invasive upper median 11:48
8 sternotomy cases. I did 12 or 13 of them and I stopped 11:48
9 doing them because I didn't see any advantage to them. 11:48

10 Those are considered minimally invasive but there 11:48
11 is a difference between that minimally invasive surgery and
12 the one you are discussing that Coy did, as I understand
13 what he did, because of the presence of the placement of the
14 retrograde cardioplegia line in the neck using
15 transesophageal echo, because some technical differences in
16 the cannulation devices that are used in the groin, and
17 because of the location of the incision from the midline of
18 the sternum to the anterior part of the chest. In my mind
19 they are different techniques. They are not the same
20 operation. But if you look up you will find them both
21 identified as minimally invasive surgery.

22 Q. Okay. 11:49

23 A. That's part of the confusion when you say 11:49
24 minimally invasive surgery is you need to be very specific
25 about what you're talking about because there are different

1 minimally invasive surgeries. They are not all the same.

2 Q. Okay.

3 A. Okay?

4 Q. What training had you done prior to performing

5 the procedure that you were describing with Dr. Kahn in, and

6 I'll represent to you that it was in late 2003, early 2004?

7 A. Mostly Dr. Kahn did it, which is why he was

8 the surgeon. Which involved going to -- I would run into a

9 definition of what is a course. Because this is I believe

10 all of these were started before there were formal CME, you

11 know, continuing medical education, accredited courses in

12 minimally invasive surgery, which I believe now exists. And

13 at that time we did the same thing I assume Coy did, which

14 is you can go to programs by the companies who have courses

15 that they gave and to how you do the procedure, how you use

16 the equipment. Although they were not CME recognized. And

17 then also going to watch other surgeons who are familiar

18 with doing the technique and doing it -- and watching them

19 do it and then having one of them come as a proctor,

20 generally someone who the company who makes all of its

21 equipment has hired to come with you when you're doing the

22 cases initially. That's what my case involved. That's what

23 Kahn went and did. I think he may have taken one of the

24 nurses with him, although I'm uncertain of that.

25 And I also believe that the anesthesiologist who

11:49

11:49

11:49

11:50

11:51

1 was principally involved in doing this did some additional
2 training in terms of learning to -- how to place the
3 transesoph -- how to place the retrograde cardioplegia line
4 into the transesophageal echo. Those things were done.

5 I did not do those. I saw some movies of them 11:52
6 doing this but actually the person who went and did the
7 training and went through with the companies and went
8 through the observation was Dr. Kahn, consequently he is the
9 one who did this operation on my patient as opposed to me
10 doing it.

11 Q. Okay. 11:52

12 A. Does that get what you needed to know? 11:52

13 Q. That helps. 11:52

14 And you were comfortable with what you understood 11:52
15 to have been Dr. Kahn's level of preparation before this
16 procedure, correct?

17 A. Yes. 11:52

18 Q. Who was the anesthesiologist that you believe 11:52
19 had gone through this training?

20 A. Brian Hite. But I don't remember that he was 11:52
21 the anesthesiologist that did the case of mine that you were
22 referencing, because I don't remember if we did the neck
23 cannulation with the transesophageal echo with the
24 cardioplegia line. If we did do that, then he was probably
25 the anesthesiologist for it. But I am not sure we would

1 to these four cases?

2 A. That is correct. 12:04

3 MS. MCCLAIN: I need to take about five minutes. 12:04

4 (Recess held.) 12:44

5 (WHEREUPON, THE LUNCH RECESS WAS HELD.) 12:44

6 (AFTERNOON SESSION.) 12:44

7 1:03 P.M. 12:44

8

9 **EXAMINATION (RESUMED)** 13:03

10 BY MR. EMBLIDGE: 13:03

11 Q. Dr. Iverson, I took Dr. Isenberg's deposition, 13:03
12 in the course of the deposition I asked about the
13 Cardiotoracic Peer Review Committee and he expressed that
14 he had some concerns about that committee. And he had some
15 concerns he said about their objectivity. And he said the
16 following: I came to understand that all of the members of
17 the Peer Review Committee were present for the entirety of
18 the discussion of cases; that an individual surgeon, whose
19 case was under discussion, did not leave the room at the
20 time of deliberations.

21 In your experience did he misunderstand the process 13:04
22 of the Cardiac Surgery Peer Review Committee?

23 MS. MCCLAIN: Objection, calls for speculation. 13:04

24 THE WITNESS: I can't speak to his understanding 13:04
25 but I can tell you that's not the way we did it.

1 Peer Review Committee?

2 A. I don't recall. 13:20

3 Q. Do you recall these cases ever being reviewed 13:20
4 by the Cardiothoracic Peer Review Committee?

5 A. To my knowledge, they were never reviewed 13:20
6 there.

7 Q. Can you think of any other instance where a 13:21
8 cardiothoracic surgeon's patient care activities have been
9 reviewed by other bodies within Summit, despite not having
10 been first reviewed by the Cardiothoracic Peer Review
11 Committee?

12 A. I am not. 13:21

13 Q. Do you have any understanding as to why that 13:21
14 occurred in this case?

15 A. No. 13:21

16 Q. Did you ever have any discussion with anyone 13:21
17 about whether these cases should be reviewed at the
18 Cardiothoracic Peer Review Committee?

19 A. No. 13:21

20 Q. Did you ever review these cases? 13:21

21 A. No. 13:21

22 Q. This was a -- this document says -- it's 13:22
23 entitled a special meeting but it doesn't say of who. What
24 was your understanding of this body that was meeting?

25 A. It was to discuss the curtailment of doing the 13:22

1 A. I recall that the committee did not accept the 13:38
2 reviewer's position. That's all I recall.

3 Q. Do you -- can you recall anytime where that's 13:39
4 happened with a cardiac surgeon, that -- that the Surgery
5 Peer Review Committee did not accept a physician reviewer's
6 findings about care issues?

7 A. I recall that there were times when a reviewer 13:39
8 presented a case with questions that were discussed in the
9 Peer Review Committee, and the committee disagreed or
10 altered the conclusion of the specific referring
11 physician -- the specific reviewing physician. I don't 13:39
12 recall what they were or that there were major issues but I
13 know that that has occurred.

14 Q. Do you recall any situation where the 13:39
15 committee voted not to accept the peer reviewer's findings
16 about care issues?

17 A. After the discussion with the peer reviewer, 13:40
18 the peer reviewer generally changed, went along with the
19 committee. I don't recall that there ever was an issue
20 where the peer reviewer had his grounds and the committee
21 refused to accept it. I don't recall that happening.

22 Q. It goes on to say that -- on the next page -- 13:40
23 members felt physicians' specific concerns including final
24 care determinations for the cases should be reconsidered by
25 the officers.

1 My first question is probably just a quibble with
2 the word reconsidered.

3 Were you aware of the officers having been --
4 having made care determinations at this point?

5 A. No.

6 Q. Have there been situations that you recalled
7 that a Surgery Peer Review Committee chose not to make care
8 determinations regarding a surgeon's care deferring instead
9 to the officers?

10 A. No.

11 Q. It then goes on to say that it was also
12 recommended that X number of all minimally invasive
13 procedures no matter the surgeon be reviewed.

14 Do you recall that discussion?

15 A. I recall such a discussion but I don't recall
16 as to whether it was at this meeting. I am afraid it was an
17 agreed on thing before this meeting occurred, that all those
18 cases would be reviewed because it was a new procedure.
19 Which is fairly standard in a peer review situation when
20 somebody comes up with a new procedure, regardless of what
21 it is, that the first X number of cases are reviewed.

22 Q. Did that happen? Did there -- was there a
23 formal review of all minimally invasive procedures?

24 A. I don't know.

25 Q. You don't recall that one way or the other?

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1 Ms. McClain's office to prepare for this deposition? 14:41

2 A. No. 14:42

3 Q. Apart from knowing that Dr. Monte Paxton was 14:42
4 the head of the Ad Hoc Committee in this case, do you have
5 any relationship with him? 14:42

6 A. Colleagues at Summit. 14:42

7 Q. Would you call him a friend? 14:42

8 A. Much like Art Stanton or Dr. Ennix prior to 14:42
9 the lawsuit. 14:42

10 Q. Is he someone you socialized or golfed with? 14:42

11 A. I think he and I may have played golf once. 14:42

12 Maybe twice. 14:42

13 Q. And what about Dr. Moorstein, is he someone 14:42
14 that you have any social relationship with -- 14:42

15 A. Yes. 14:42

16 Q. -- outside of work? 14:43

17 A. Yes. 14:43

18 Q. How would you describe your relationship with 14:43
19 him? 14:43

20 A. We are good friends. 14:43

21 Q. You still keep in touch? 14:43

22 A. Yes. 14:43

23 Q. You talk to each other regularly? 14:43

24 A. I wouldn't say regularly but often. 14:43

25 Q. How about Dat Ly, do you have any relationship 14:43

1 STATE OF CALIFORNIA)
2) ss.
COUNTY OF MONTEREY)

3
4 The witness in the foregoing deposition appeared
5 before me, JENNA OSBORN, Certified Shorthand Reporter No.
6 8681 for the State of California.

7 Said witness then and there at the time and place
8 previously stated testified under penalty of perjury given
9 on said day.

10 The testimony of the witness and all the questions
11 and remarks requested by counsel were taken by me in
12 shorthand at the time and place therein named and
13 thereafter, under my direction, transcribed into
14 longhand.

15 I further certify that I am not of counsel or
16 attorney for either or any of the parties to said
17 deposition, nor in any way interested in the outcome of the
18 cause named in said caption and that I am not related to
19 any party thereto.

20 IN WITNESS WHEREOF, I have hereunto set my hand
21 this 28th day of December, 2007.

22 
23
24 CERTIFIED SHORTHAND REPORTER
25 FOR THE STATE OF CALIFORNIA

EXHIBIT L

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

--oo--

COYNESS L. ENNIX, JR., M.D., as
an individual and in his
representative capacity under
Business & Professions Code
Section 17200, et seq.,

CERTIFIED COPY

Plaintiff,

NO. C 07-2486

vs.

RUSSELL D. STANTEN, M.D., LEIGH
I.G. IVERSON, M.D., STEVEN A.
STANTEN, M.D., WILLIAM M.
ISENBERG, M.D., Ph.D., ALTA
BATES SUMMIT MEDICAL CENTER and
DOES 1 through 100,

Defendants.

Deposition of

DEBORAH MOGG

January 31, 2008

HANNAH KAUFMAN & ASSOCIATES
Certified Shorthand Reporters
472 Pacheco Street
San Francisco, California 94116
(415) 664-4269

Reported by:
THOMAS J. LANGE
CSR No. 4689
Registered Merit Reporter

1 Q. When did you become the Quality Improvement
2 Coordinator for the department of surgery?

3 A. I would have to guess. I'm not quite -- end
4 of --

5 Q. I want to interrupt you. "Guess" is a word
6 that sends shivers up and down the spines of lawyers.
7 Okay?

8 A. Okay.

9 Q. So I want to give you the example I usually
10 give witnesses about guessing and estimating. If I ask
11 you to estimate the length of this table, well, you can
12 look at it and you can give me a reasonable estimation.
13 If I asked you to estimate how many chairs are in the
14 other conference room, that would be a total guess
15 because you haven't seen the other conference room.
16 Right?

17 A. Okay.

18 Q. I'm entitled to your best estimation or best
19 approximation, and so on this question, for example, I
20 just want your best approximations based on your own
21 personal knowledge of your job history, when you became
22 the Quality Improvement Coordinator for the surgery peer
23 review.

24 A. My best estimate would be the end of 1998.

25 Q. Have you had any experience with the peer

1 A. Pat Gardner.

2 Q. Gardner?

3 A. Yes.

4 Q. And is she still at Summit?

5 A. Yes.

6 Q. Okay. So we have talked about nurse level
7 review, physician level review, then some cases get
8 reviewed by the surgery peer review committee itself.
9 Correct?

10 A. I said I don't recall if -- you mean bypassing
11 the physician level of review?

12 Q. No, no. The surgery peer review committee on
13 occasion reviews cases for quality issues. Correct?

14 A. The physician reviewer presents the case and
15 they discuss it.

16 Q. Okay. And what are the possible outcomes of
17 the discussion at the surgery peer review committee of
18 the case?

19 MR. VANDALL: Objection, vague, incomplete
20 hypothetical.

21 THE WITNESS: There's several possibilities of
22 what could happen. The committee could decide there is
23 no care issue and close it themselves. They may write a
24 letter to the physician asking for more information.
25 They may decide that the issues are not relevant with

1 Q. Then there are cases that get actually reviewed
2 at the committee level for care issues, right?
3 A. Correct.

4 Q. How many of those, the latter, do you recall in
5 any given month or year?

6 MR. VANDALL: Objection, vague.

7 THE WITNESS: Zero to four in a month.

8 Q. BY MR. EMBLIDGE: Since 2001 have you attended
9 cardiothoracic peer review committee meetings?

10 A. If 2001 is when I stopped doing it, I don't
11 attend them once I stopped coordinating that committee.

12 Q. When the rules and regulations referred to
13 cases falling out, in your work on the surgery peer
14 review committee, is that the same as cases having the
15 quality indicators listed on Exhibit --

16 MR. VANDALL: 1200.

17 Q. BY MR. EMBLIDGE: -- 1200?

18 A. Yes, means they fell out for the generic
19 indicators listed there.

20 Q. Have you ever attended MEC meetings?

21 A. No.

22 Q. Is there a quality improvement coordinator
23 assigned to the MEC?

24 A. No.

25 Q. When you select the physician, either on your

1 own or in consultation with the chair, to review a
2 particular case at the surgery peer review committee, do
3 you always select a physician with the same specialty as
4 the physician being reviewed?

5 MR. VANDALL: Objection, asked and answered.

6 THE WITNESS: I believe so, yes.

7 Q. BY MR. EMBLIDGE: Okay. Let me just take a
8 one-minute break, and we will be done.

9 (Recess taken from 3:06 to 3:09 p.m.)

10 MR. EMBLIDGE: Just a couple of questions.

11 Q. You talked about an instance where the surgery
12 peer review committee, the chair of the surgery peer
13 review committee sent a letter to Dr. Ennix about the
14 need to submit an operative report. Do you recall that?

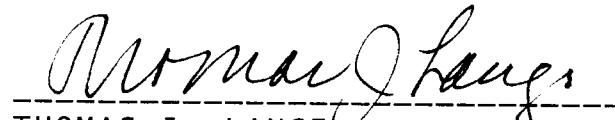
15 A. Uh-huh, yes.

16 MR. VANDALL: Objection, outside the scope of
17 the deposition.

18 Q. BY MR. EMBLIDGE: In your experience in the
19 peer review committee, the surgery peer review
20 committee, has that ever happened regarding any other
21 physician?

22 MR. VANDALL: Objection, outside the scope of
23 the deposition.

24 THE WITNESS: The cardiac surgery committee
25 asking the surgery committee to send a letter? or any

1
2 REPORTER'S CERTIFICATE
3
45 I certify that the foregoing proceedings
6 in the within-entitled cause were reported at the time
7 and place therein named; that said proceedings were
8 reported by me, a duly Certified Shorthand Reporter
9 of the State of California, and were thereafter
10 transcribed into typewriting.11 I further certify that I am not of counsel or
12 attorney for either or any of the parties to said cause
13 of action, nor in any way interested in the outcome of
14 the cause named in said cause of action.15 IN WITNESS WHEREOF, I have hereunto set my hand
16 this 12th day of February, 2008.
1718
19 
20 THOMAS J. LANGE
21 Certified Shorthand Reporter
22 State of California
23 Certificate No. 4689
24
25